

## Humana Specialty Pharmacy®

Monday – Friday, 8 a.m. – 11 p.m., and  
Saturday, 8 a.m. – 6:30 p.m., Eastern time

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

### Synagis® Prescription Form

#### Patient information

Patient: \_\_\_\_\_  Female  Male DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  lb  kg Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_  
 Home phone #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_ Caregiver: \_\_\_\_\_ Caregiver phone #: \_\_\_\_\_  
 Other medical conditions: \_\_\_\_\_ Allergies:  No  Yes: \_\_\_\_\_  
 Insurance plan: \_\_\_\_\_ Plan ID #: \_\_\_\_\_ BIN: \_\_\_\_\_ PCN: \_\_\_\_\_ Group #: \_\_\_\_\_  
 \*Please send a copy of the patient's prescription insurance card if available.

#### Clinical information

Diagnosis(es):	Additional information
<input type="checkbox"/> ≤ 28 completed weeks of gestation (P07.30 - 7.31) <input type="checkbox"/> 29 completed weeks of gestation (P07.32) <input type="checkbox"/> 30 completed weeks of gestation (P07.33) <input type="checkbox"/> 31 completed weeks of gestation (P07.34) <input type="checkbox"/> 32 completed weeks of gestation (P07.35) <input type="checkbox"/> 33 completed weeks of gestation (P07.36) <input type="checkbox"/> 34 completed weeks of gestation (P07.37) <input type="checkbox"/> 35 completed weeks of gestation (P07.38) <input type="checkbox"/> Congenital heart disease (ICD-10): _____ <input type="checkbox"/> Severe chronic lung disease (CLD)(ICD-10): _____ <input type="checkbox"/> Cystic fibrosis (ICD-10): _____ <input type="checkbox"/> Neuromuscular disease (ICD-10): _____ <input type="checkbox"/> Profoundly immunocompromised (ICD-10): _____ <input type="checkbox"/> Congenital anomalies of the airway (ICD-10): _____	Synagis® dose(s) already administered? <input type="checkbox"/> No <input type="checkbox"/> Yes Date(s): _____ Gestational age (GA) at birth: _____ Multiple births: <input type="checkbox"/> No <input type="checkbox"/> Yes Current weight: _____ kg _____ lbs-oz Date weight recorded: _____ Clinical conditions: <input type="checkbox"/> < GA 28 weeks, six days <b>and</b> < 12 months at start of season <input type="checkbox"/> Chronic lung disease <b>and</b> < 12 months of age with GA < 32 weeks <b>and</b> required > 21% O <sub>2</sub> for at least first 28 days after birth <input type="checkbox"/> Chronic lung disease <b>and</b> 12–24 months of age with GA < 32 weeks <b>and</b> has required any of the following therapies within the past six months: <input type="checkbox"/> Oxygen date: _____ <input type="checkbox"/> Corticosteroids date: _____ <input type="checkbox"/> Bronchodilators date: _____ <input type="checkbox"/> Diuretics date: _____ <input type="checkbox"/> Hemodynamically significant congenital heart disease <b>and</b> < 12 months of age at start of season <input type="checkbox"/> Moderate to severe pulmonary hypertension (I27.2) <input type="checkbox"/> Cyanotic CHD (I24.9) <input type="checkbox"/> Meds for CHD: _____ Date CHD med last received: _____ <input type="checkbox"/> Compromised handling of secretions <b>and</b> < 12 months of age at start of season due to: <input type="checkbox"/> Significant abnormality of the airway (attach clinical notes) <input type="checkbox"/> Neuromuscular condition (attach clinical notes)

#### Prescription information

Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Medication	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Synagis® (palivizumab) 50 and/or 100 mg vials	<input type="checkbox"/> 15 mg/kg IM	<input type="checkbox"/> IM once monthly (every 28–30 days)	_____	_____
<input type="checkbox"/> Epinephrine 1:1000 ampule	<input type="checkbox"/> Inject 0.01 mg/kg	<input type="checkbox"/> SC as directed for anaphylaxis	Other	None

Supplies: (Supplies will not be sent with shipment unless indicated.)  
 Administration supplies consisting of: • Alcohol prep pads • 3 mL 25G x 5/8" safety glide syringes • 25G 1" safety glide needles • Curity flexible bandages • 1 mL 25G x 5/8" safety glide syringe supplies for epinephrine (if prescribed) • 19G x 1 1/2" 5M filter needle • 1 mL 27G x 1/2" TB syringe with needle Send quantity sufficient for medication days' supply.

Skilled nursing visit to provide parent education related to therapy and disease, administer medication as prescribed, assess general status and response to therapy. Visit frequency based on prescribed dosage orders.

Need by date: \_\_\_\_\_

Expected date of next injection: \_\_\_\_\_

#### Prescriber and shipping information (please print)

Prescriber: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Ship to:  Patient  Office  Other: \_\_\_\_\_  
 Office address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_  
 Office phone number: \_\_\_\_\_ Office fax number: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

We will dispense this prescription as generic, unless the prescriber indicates "Dispense as Written" here: \_\_\_\_\_

The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form and fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.